EXHIBIT 6
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SB 417

MHA AN ASSOCIATION OF MONTANA HEALTH CARE PROVIDERS

Testimony on SB 417
Before the House Business and Labor Committee

By Bob Olsen, Vice President, MHA
March 22, 2007

Senate Bill 417 proposes to extend for two years the existing moratorium on licensing specialty hospitals. This bill presents Montana an opportunity to pause and consider the impacts that specialty hospitals have on access to care, health care costs, provider competition and the quality of services provided by all hospitals.

Public policy in Montana pertaining to specialty hospitals and other niche providers will have a fundamental and lasting affect on health care services. The moratorium is a reasonable way to make sure that no existing facility is prevented from providing services while public policy is established.

The provisions of SB 417 include:

- A state definition of what a specialty hospital is, and what it is not;
- Language to provide administrative guidance to the Department of Public Health and Human Services;
- A two-year extension of the current moratorium;
- Language to clarify that an existing health care facility can not become a specialty hospital; and
- The bill does not apply to hospitals, or specialty hospitals that now exist.

Section 1. This section takes up all but the last page of the bill. There are no amendments to the current statute for the first 7 pages of the bill. Beginning on page 8 line 2, SB 417 provides a definition of a specialty hospital. This language is necessary because the definition used in the current statute relies on a definition in federal law. That federal law has expired.

> The federal definition read: "1877(h)(7)(A) For purposes of this section, except as provided in subparagraph (B), the term "specialty hospital" means a subsection (d) hospital that is primarily or exclusively engaged in the care and treatment of one of the following categories:
>
> 1877(h)(7)(A)(i) Patients with a cardiac condition.
>
> 1877(h)(7)(A)(ii) Patients with an orthopedic condition.
>
> 1877(h)(7)(A)(iii) Patients receiving a surgical procedure.

1877(h)(7)(A)(iv) Any other specialized category of services that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

MHA intends to follow the federal pattern. We are also providing a workable definition to serve the Department of Public Health and Human Services concerns about the licensing process. We differ from the federal definition in two ways. First we provide a measure for the Department to use to determine whether a facility is, or is not, a specialty hospital. Second, we list the kinds of facilities that are not subject to the moratorium.

SB 417, beginning **on line 4 of page 8, lists the categories of hospitals that are to be considered to be specialty hospitals**, and thus subject to the moratorium. The list includes cardiac, orthopedic, surgical and cancer hospitals.

Subpart b of the bill, beginning on line 13, provides guidance to the Department about how to make a determination whether a hospital is a general acute care hospital, a specialty hospital or a hospital exempt from the moratorium. This guidance is in the form of allowing up to 35% of the hospital services to be in areas other than the specialty services. A hospital whose services fall within this guideline may be determined to be a specialty hospital. If more than 35% of the services fall into other areas of care the hospital can be determined to be a general acute care facility.

Subpart c, beginning on line 16, provides a list of exemptions from the definition of a specialty hospital. The hospitals on this list are not typically established to compete directly with a general acute care hospital and are typically providing services that are more dependent on Medicare, Medicaid and other government programs.

Beginning on line 26 of page 8 and ending on line 15 of page 15 the bill strikes out old language in the statute. This strikeout does not amend the current statutes, it is merely housekeeping.

Section 2. SB 417 amends MCA 50-5-203 by providing guidance to the Department for the application process. Since this bill only applies to new hospitals, there is no historical record of service to evaluate. The Department will need to review documentation that supports the applicants intentions, or to rely upon attestation by the applicant when considering an application.

Section 3. SB 417 amends MCA 50-5-245 by striking out the expired federal definition of a specialty hospital, **and extending the moratorium period until July 1, 2009**. Beginning on line 12 of page 16, language is added to specify that existing hospitals are not prevented from changing their services.

Section 4. Repealer.

Section 5. SB 417 provides that the effective date is upon passage and approval.

Section 6. The moratorium does not apply to any hospital that exists prior to the adoption of this statute. This means that the problem that occurred in Great Falls, in which Benefis and the Central Montana Hospital ended up in a hotly contested interpretation of the statute, won't happen again. The Montana Supreme Court, in its deliberations, noted that they believed the existing state statute was vague on this point. The moratorium simply does not apply to an existing hospital. The bill only applies to a new hospital.

MHA urges your support for SB 417.

MHA

AN ASSOCIATION OF MONTANA HEALTH CARE PROVIDERS

What are Specialty Hospitals?

- Specialty hospitals – or limited service providers as they are also called – focus on specific treatment procedures and conditions – e.g. heart, orthopedic surgical services and cancer treatment.
- SB 417 focuses on specialty hospitals. However, there also are a number of other outpatient specialty health care facilities, including ambulatory surgery centers, imaging centers and birthing centers.
- Specialty hospitals typically are for-profit facilities owned by physicians or large for-profit corporations.
- Commonly, they do not provide emergency department services and other services that are not profitable.

Legislative History

- In recognition of the proliferation of specialty hospitals, Congress in 2003, in the Medicare Modernization Act, imposed a moratorium on physician self-referral of Medicare and Medicaid patients to new limited-service hospitals. This moratorium expired in 2005, however, due to federal regulatory and statutory actions, in effect, it continued until August 2006.
- The federal moratorium defined specialty hospitals as facilities that primarily perform orthopedic, surgical, cardiac and cancer treatment procedures.
- During the interim, Congress directed the Medicare Payment Advisory Commission and the Centers for Medicare & Medicaid Services to conduct studies to determine the impact of specialty hospitals in the health care delivery system and to identify appropriate public policies.
- In Montana, legislation sponsored by Sen. Dan Harrington was enacted in 2005 to impose a moratorium on licensure of new specialty hospitals. The moratorium expires July 1, 2007. This legislation was designed to give Congress more time to determine public policy in this area.
- Congress continues to wrestle with this issue.

Specialty Hospitals have Adversely Affected Physician-Hospital Relations

- Physicians are the backbone of hospitals. Hospital administrators and boards of trustees do not admit patients or perform procedures – physicians do. For this reason, it is essential that hospitals and physicians work together for the benefit of patients.
- The rise of specialty hospitals and other limited service providers has severely strained physician-hospital relations.
- The threats posed by the increase in the number of limited service providers have forced hospitals to seek legislative assistance through an extension of the state moratorium.

Specialty Hospitals Can Cause Great Harm

- Limited service hospitals can cause great financial harm to full-service hospitals and the health care safety net.
- Why? Evidence is mounting that specialty hospitals accept patients who are well-insured for procedures that pay well. This takes away revenue that full-service hospitals need to offset the care they provide uninsured and charity care patients who require procedures that don't pay well.
- The effect of this "cherry-picking," is to weaken the health care safety net.

Physician Ownership Presents a Major Public Policy Issue

- Physicians have a financial incentive to refer patients to facilities that they own, which raises conflict-of-interest issues.
- Federal legislation ("Stark laws") in the late 1980's prohibited physician self-referral in certain circumstances, but did not address specialty hospitals.
- The rise of specialty hospitals has sparked proposals to ban all physician self-referral.

Specialty Hospitals & Competition

- Competition on a level playing field between full-service and limited-service hospitals can benefit the patients, communities and regions we serve.
- Unfair competition weakens the health care safety net provided by non-profit, community-based hospitals.

Growth of Niche Providers Drives Costs

- The proliferation of specialty hospitals and providers of niche services drives up health care costs by creating new capacity in the health care delivery system.
- It is important to balance the cost of duplicating health care services within a community with the additional consumer choice that is provided.

Specialty Hospitals Remain a Major Issue in Congress

- The federal moratorium has expired.
- The Centers for Medicare & Medicaid Services (CMS) has implemented reimbursement changes in an effort to remove the financial incentives that encourage physicians to refer patients to facilities that they own.
- However, it will take some time to determine if this effort will effectively level the playing field.
- Congress has renewed efforts to halt development of specialty hospitals and restrict physician self-referral.
- For these reasons, an extension of the state moratorium is needed to give Congress time to finish its work.

SB 417 Would Extend the State Moratorium

- SB 417 would extend the moratorium until July 1, 2009.
- This would give additional time for Congress to fashion a nationwide solution to this issue.
- This bill also would give the Department of Public Health and Human Services direction in developing rules to implement this statute.

Ending the Moratorium Would Lead to Proliferation of New Specialty Hospitals

- In communities in which there is no moratorium has experienced the significant negative effects of the development of specialty hospitals.

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Gazette Opinion: Red flags on specialty hospital development

On Friday, the Montana House Business and Labor Committee Committee will hold a hearing on extending a moratorium on opening new specialty hospitals "exclusively engaged in" surgery or the diagnosis, care or treatment of cardiac, orthopedic or cancer conditions. Psychiatric, rehabilitation, children's care, long-term care and critical access hospitals are specifically excluded from the definition.

This distinction is being drawn, not just in Montana, but across the country because of recent development of hospitals (usually owned fully or partly by physicians) that specialize in the types of cases that are the most financially rewarding among the many services provided by general hospitals. Congress put the brakes on these new facilities because of cost concerns and worries about what may happen to the general service hospitals that communities count on to take care of all their needs 24/7, regardless of ability to pay. In Montana, all of the community hospitals are nonprofit organizations pledged to care for anyone who comes through their doors.

Two years ago, the Montana Legislature enacted a two-year moratorium on new specialty hospitals. It will sunset this June unless extended through Senate Bill 417, which drew strong bipartisan support in the Senate, passing on a vote of 39 to 11. Introduced by Sen. Roy Brown, R-Billings, the bill's 15 cosponsors include Sens. Kim Gillan and Lynda Moss and Wanda Grinde, all Billings Democrats, as well as Sen. Kelly Gebhardt and Rep. Alan Olson, both Roundup Republicans.

A companion bill, Senate Joint Resolution 15, introduced by Gillan and Brown, requests an interim study on how physician-owned health-care facilities and specialty hospitals would affect Montana's health system. Together, SB417 and SJR15 would give Montana two years and better information for making decisions in 2009.

Meanwhile in Washington, D.C., specialty hospitals face an uphill battle. The new chairman of the Senate Finance Committee, Max Baucus of Montana, had this to say last week: "My strongly held view on doctor-owned specialty hospitals is that they undermine the basic system." Baucus told The Gazette that specialty hospitals tend to increase costs and to decrease access for all to health care. He predicted "there will be opportunities to pass legislation to stop these specialty hospitals." The ranking minority member of the Finance Committee, Sen. Charles Grassley, R-Iowa, agrees with Baucus. In the House, Ways and Means Committee Chairman Rep. Pete Stark, D-Calif., has long taken a hard line against letting doctors refer Medicare patients to facilities in which the doctors are investers.

There are between 130 and 140 specialty hospitals in the United States, almost all developed before a 2003 federal ban took effect, according to the Congressional Quarterly Weekly. In the six months since the ban expired, at least 30 new specialty hospitals have broken ground. Congressional Quarterly Weekly also reported last month that high costs have prompted some private insurers to refuse to admit specialty hospitals to their networks.

At a U.S. Senate hearing last year, Baucus noted that the General Accountability Office found that, in the aggregate, specialty hospitals had little effect on the survival of full-service community hospitals. But the Medicare Payment Advisory Commission found that specialty hospitals are more expensive than full-service hospitals and the nonpartisan Congressional Budget Office also believes that specialty hospitals drive up health costs.

Perhaps, there are circumstances in which stand-alone cardiac or orthopedic hospitals will benefit Montana communities. But there are enough red flags about these new hospitals to warrant a cautious approach to protect the fragile safety net that cares for all Montanans. The Montana House committee should add its endorsement to the the Senate's and urge the full House to send SB417 and SJR15 to Gov. Brian Schweitzer for his signature.

American Hospital Association

The Health Care Market Must Protect Against Conflict of Interest:

Talking Points

Fair competition is the hallmark of our country's free market system. To ensure fair competition, rules and regulations are in place to make sure conflicts of interest do not interfere with market forces. We see this everyday with the stock market, where brokers are banned from hyping a stock in which they have an ownership stake. We also see it in rules prohibiting insider trading.

And yet a physician, under the guise of "free market competition" can refer carefully selected patients to a limited service hospital the physician owns for personal gain. Physician self-referral is anti-competitive and we ask whether those who seek to retain conflict of interest policies have as their "bottom line" what's right for patients and communities?

For America's full-service community hospitals, the real bottom line is our top priority: getting people the right care, at the right time, in the right place. Does physician self-referral to limited-service hospitals have that same bottom line at heart? Let's look at the facts:

- Physician self-referral allows physician-owners to profit by referring carefully selected patients to the facilities in which they have an interest. Economically unattractive patients are avoided or sent to the community hospitals.

- **The Medicare Payment Advisory Commission (MedPAC) has found that limited-service hospitals treat far fewer Medicaid recipients** than community hospitals in the same market – 75 percent fewer for physician-owned heart hospitals and 94 percent fewer for orthopedic hospitals. The General Accountability Office (GAO) reports similar results.

- **According to MedPAC, limited-service hospitals concentrate on services that bring the highest profits, and treat patients with the least-complex cases.** This leaves the more complex, lower-reimbursement patients to full-service community hospitals. The GAO also found that limited-service hospitals serve patients who are less sick.

- Studies by O'Melveny & Myers LLP and KPMG found that:

    - **The rate of return on investment by physicians in limited service hospitals are extraordinary**, with physicians making at least three to five times their original investment in a short period of time;

(over)

- **Interests in the limited service facility are offered solely to those physicians in a position to refer to the facility;**
- Shares or interests are offered to physicians at prices heavily discounted below fair market value;
- The risks physician investors are taking in exchange for these returns is minimal; and,
- **Physicians are responding to these returns by referring, almost from day one of their investment, their profitable business to the facility in which they have an investment interest.**

- Competition in healthcare should provide greater efficiencies and bring costs down. However, **MedPAC found that physician owned limited service hospitals <u>do NOT have lower costs</u> than full service hospitals—raising serious questions about whether they are in fact "more efficient " or "lower cost."**

Full-service community hospitals welcome competition from limited service hospitals and others —they compete successfully everyday in communities across the country based on quality, price, and services. The issue is not competition, but rather the blatant conflict of interest that exists when a physician is an owner of a limited service hospital <u>and</u> controls patient referrals.

Competition is supposed to be about consumer choice. As currently structured, this system is all about physician-owner choice – not patient choice. And, it leads to manipulation of the Medicare payment system for personal gain. It is not fair and open competition, it is egregious anticompetitive behavior. And it leads to decisions being made not in the best interests of a patient, but rather on the financial interests of the doctor.

To be clear, the existence of limited-service hospitals in the marketplace is not the issue nor is there an issue with physicians having ownership in a hospital to which they do not refer—it is the combination of ownership and self-referral that is anticompetitive at its core.

The solution is clear: Ensure a fair health care marketplace, eliminate conflict of interest, and ban, permanently, physician self-referral to new limited-service hospitals.

Cover Story » *Jessica Zigmond*

BETTING BIG ON DOC OWNERSHIP

'Boutique' chain blasts off with $1 billion investment, plans for 10 hospitals, and hopes to create healthcare model of the future

Former stockbroker Kamran Nezami and his physician partners believe their business plan for physician-owned hospitals is the healthcare model of the future, and a North Carolina development company is betting $1 billion that they're right.

Although the physician ownership concept is not new, the agreement between Nezami's University General Hospital Systems in Houston and Charlotte, N.C.-based Alliance Development Group is unique not only for its size, but also because it involves many of healthcare's hottest issues. Patient care, payer mix, physician financial interest, managed-care network contracts, and the ongoing struggle between small, "boutique" facilities and their large community hospital counterparts—this deal has it all.

In the $1 billion transaction—which the two companies signed Nov. 30 and announced the next day—Alliance will work with UGHS to build 10 physician-owned, general acute-care hospitals in various markets nationwide. Alliance will handle the real estate and lease the facilities to UGHS, which will manage and operate the approximately 80-bed hospitals. The companies expect to break ground on a facility in Houston's Chinatown area in the first quarter of 2007, and plan to begin building a new facility every three months, Nezami said. In addition to Houston, he listed Dallas, Denver and Phoenix as some of the sites, and said other markets would be announced later.

All of the markets are in states without certificate-of-need laws except for one, Nezami said. W.J. "Bill" Burk, president and chief executive officer at Alliance, identified Hawaii (which has a CON program) as another site, and there could be additional projects, but 10 is an appropriate number for now. Nezami said UGHS would like to build in Hawaii, but it would be a "tough battle" because it's a CON state.

The project is likely to attract a lot of attention with so many eyes already focused on the specialty hospital industry, and acute-care hospital executives making a case with Congress to limit physicians in their ownership of hospitals.

"For us, the issue all along has been physician ownership and self-referral," said Carmela Coyle, senior vice president for policy at the American Hospital Association. "It is less (about) limited service. The concern is whether the physicians are acting in the best interest of the patients or their own financial interest."

But the outcry over specialty hospitals and physician ownership hasn't deterred Nezami and his partners from the project, the roots of which go back more than a decade.

As a stockbroker with Merrill Lynch & Co. in the mid-'90s, Nezami said he had physician clients and understood that baby boomers would be putting their money into healthcare. Originally, Nezami had planned to develop an ambulatory surgery center until physician partner Hassan Chahadeh said they should build a hospital. "What happens with these major hospital systems is there is a huge bureaucracy. Things rarely get done. Nobody (is) motivatec to make decisions or any changes," Nezami said. University General Hospital Systems has set ou to fix that, and Nezami said he thinks the mode will change the face of healthcare in America.

The company began in May 2005, whei Nezami and physicians Chahadeh, Octavi Calvillo, Henry Small and Felix Spiegel forme University Hospital Systems, a private, for-profi company that developed University Genera Hospital—a 72-bed Houston facility tha opened in September and was granted accredi tation by the Joint Commission Accreditatio of Healthcare Organizations, effective Dec. 1.

About 70 physicians are limited partners an own about 65% of the facility, or roughly 1% each, while Nezami, Chahadeh, Calvillo, Sma and Spiegel are general partners and own th remaining 35% interest. The company lat formed University General Hospital System which will oversee the future projects and hav

THE TWO PARTNERS

A snapshot of the two companies that are joining together in a $1 billion plan to create a chain of 10 smaller acute-care facilities.

University General Hospital Systems

- Kamran Nezami, president and CEO
- Private, for-profit healthcare company
- Established in 2006
- Revenue: Declined to provide
- Employees: 15

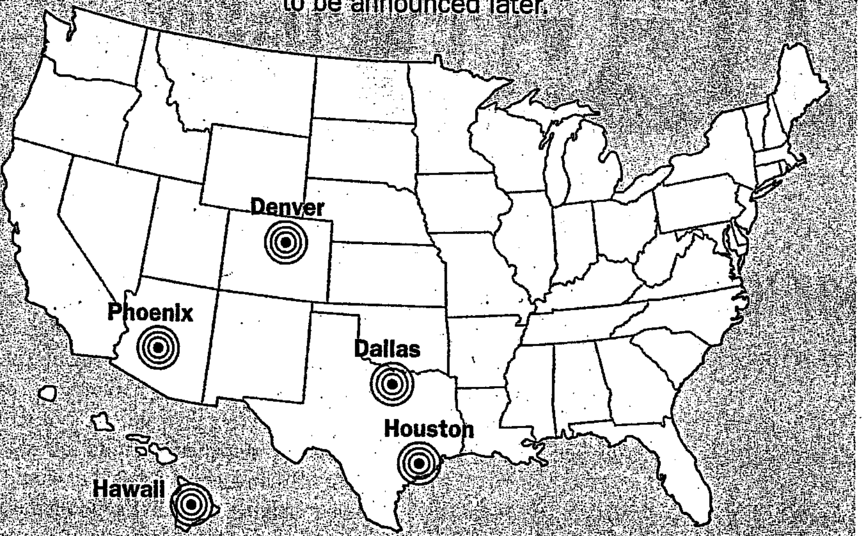
Alliance Development Group

- W.J. "Bill" Burk, president and CEO
- Private real estate services company in healthcare, casual dining, banking
- Established in 2004
- Revenue: Declined to provide
- Employees: 20 (estimated)

Sources: University General Hospital Systems, Alliance Development Group

TARGET MARKETS

University General Hospital Systems and Alliance Development Group are planning to expand their chain of physician-owned, acute-care hospitals in the following areas, with other markets to be announced later.

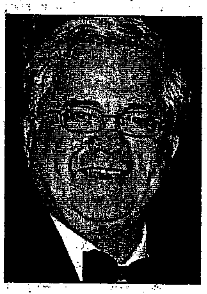


Sources: University General Hospital Systems, Alliance Development Group

a similar ownership breakdown. UGHS includes the same general partners except for Calvillo, Nezami said.

Some practitioners agree with Nezami that physician ownership is an effective model. Robert Davis, a limited partner and general surgeon who works at both University General Hospital and 911-bed Methodist Hospital in Houston is among those. Davis, who has been a physician for 30 years, said physician groups have left Methodist because they don't see "eye-to-eye" with administrators on care.

"There is nothing wrong with Methodist," Davis said. "But there is a very deep bureaucracy. ... If you want to get an instrument you need, the layer may be 20-30 layers deep, whereas in the new hospital, we get it tomorrow. ... We can also control our expenditures. We doctors own the hospital."



Davis: Big systems are weighed down by bureaucracy.

Methodist executives weren't available for comment. Representatives for St. Luke's Episcopal Health System and 711-bed Memorial Hermann Hospital, located close to University General Hospital in Houston, also were not available for comment.

Similar to the flagship, University General Hospital, the new facilities will have the "look and feel of a Four Seasons hotel," but will provide full services, and accept any patient who walks through the door, Nezami said. They will also have strong bariatric and orthopedic components, but aren't specialty hospitals, he said.

Nezami said the real criticism from opponents is whether these hospitals care for the underinsured and uninsured. "Do we target the indigent population? No. Can we handle anyone who walks through our doors? Yes."

A Congressional Budget Office report released last week found one area where the for-profit industry serves the poor better than the not-for-profit industry (See story, p. 12).

Laura Comer, director of managed care at University General Hospital, said the hospital expects to receive its Medicare license within the month. The hospital must wait for its Medicare license before it applies for Medicaid.

One of University General Hospital's goals is to be an in-network provider, which has been proven to be a challenge. Comer said big players Aetna, Humana and UniCare have all denied University General Hospital access to their networks, and local competitors don't want the hospital in the networks for fear it might take away lucrative business.

A similar struggle happened in Kansas last year, when physician-owned Heartland Spine & Specialty Hospital in Overland Park filed suit against several hospitals and insurers for allegedly excluding 19-bed Heartland from obtaining in-network contracts (May 9, 2005, p. 6). Now in the discovery stage, the case is set for trial in April 2008, according to an attorney for Heartland.

Jared Wolfe, executive director of the Texas Association of Health Plans, acknowledged that

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CHAINS » *Vince Galloro*

'Stealth' chains lure big bucks

Small, nimble for-profit companies such as University General Hospital Systems threaten to take away the best-paying patients of established hospitals in high-growth markets that lack certificate-of-need protection, according to a new report by Moody's Investors Service.

These "stealth" companies are owned by private investors rather than through public stock ownership, so they don't have to disclose much about their strategies or deals, making it tougher for competitors to react, said Lisa Goldstein, a senior vice president and manager at Moody's.

The warning from Moody's came as Fitch Ratings said last week that it expects bad debt to continue to be a problem for investor-owned hospital companies in 2007. That problem will largely be offset by continued strength in commercial and Medicare reimbursements and the generally strong cash flow of the hospital business, Fitch said. Fitch also said it expects shareholders will increase their pressure on the companies, possibly leading to more going-private transactions like the recent leveraged buyout of HCA.

Besides University General, some other "stealth" companies cited by Goldstein include: GP Medical Ventures, Nashville, which recently won the bidding for 288-bed Carraway Methodist Medical Center, Birmingham, Ala., for $26.5 million (Nov. 13, p. 4); Rockwall Hospitals, Richardson, Texas, which has projects in four Texas cities, including Houston and Austin; and Surgical Development Partners, Brentwood, Tenn., which has two hospital projects in Houston and one in Murrieta, Calif.

They typically build their hospitals close to established acute-care hospitals and then seek to win over well-insured patients with greater amenities, Goldstein said. Their brand-new facilities have all private rooms and perks that may include Internet access, shorter wait times and valet parking, she said. Houston is the most advanced market for these new hospitals, with several projects going forward or ready to open, Goldstein said. Arizona and Nevada are two other states that would fit the profile for these new companies, she added.

Besides hospitals, many of these

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this is a legitimate concern: "I've been told of cases in Houston in which hospitals have threatened to drop health plans based on whether or not they decide to contract with other hospitals in the area."

An Aetna spokeswoman confirmed that University General Hospital is not in network but did not elaborate on why; a Humana spokesman said in a written statement that Humana considers "the topic of network contracts to be proprietary and confidential," and a spokeswoman for UniCare said while it is true that University General is not in the carrier's network, the company could not comment on the specific case.

Blue Cross and Blue Shield of Texas agreed to an indemnity insurance contract with University General Hospital for 55,000 lives pending the hospital's certification, according to a Blues spokeswoman.

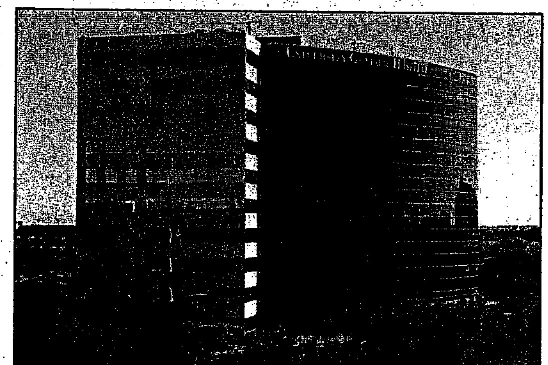
Nezami said the business plan was set up to prepare for potential payer problems. "You have to have the right volume," Nezami said. "You have to find the busiest physicians to sustain the volume you need to survive, because you can't have all patients out of network."

This raises the question of payer mix. Patients who can afford services at an upscale facility such as University General Hospital benefit, while questions linger about those who cannot pay.

"The community hospital complaint is that the physicians are very selective in the patients they are treating," said Charles Bailey, spokesman for the Texas Hospital Association, of which University General is a member. "They are less acute and potentially more profitable."

These concerns mirror the arguments in the physician-owned specialty hospital debate, which culminated in August with the end of a federal moratorium on such facilities. Bailey said it is not surprising that some companies developing physician-owned hospitals will broaden their services so they do not fall under the specialty hospital definition.

At the state level, the Idaho Board of Health and Welfare voted last week to deny a petition from the Idaho Hospital Association to temporarily suspend applications for new hospital beds. According to Steve Millard, president of the hospital association, the group filed the petition after it learned of plans for a physician-owned specialty hospital in southwestern Idaho. The measure would have affected all hospitals, including some of the association's members, Millard said. The hospital association plans to continue the fight against specialty-hospital development next month when it petitions the state Legislature to make Idaho a CON state.



The Houston flagship and UGHS' other outposts will have the "look and feel of a Four Seasons hotel."

In Arizona, where UGHS plans to build, the Arizona Hospital and Healthcare Association agreed that the core of the issue is physician self-referral and that Congress should address the issue. But John Rivers, the association's president and CEO, also noted that 225,000 peop[le] have moved to the region in the past 12 month[s] and that nearly all hospitals are operating [at] capacity. Rivers said the association takes issu[e] with hospitals that may not have an emergenc[y] department or an emergency physician on staf[f].

Sharon McDonough, vice president [of] operations and chief nursing officer at Univer[-]sity General Hospital, which is near the Texa[s] Medical center, said its emergency departmen[t] has a unit secretary, two registered nurse[s] and a physician on staff at all times, an[d] that the new system's facilities will follow [a] similar model.

"They are generally welcome as long a[s] they are playing by the same rules as every[-]one else, and it sounds like UGHS is not [a] model that would be troublesome to us a[t] all," Rivers said. Rivers also cited the Med[-]Cath model as one that has been controver[-]sial to some, but not to the association.

MedCath Corp. owns a 51% stake i[n] its Arizona Heart Hospital, with physi[-]cians owning the remaining 49%. Licensed as an acute-care hospital, th[e] 59-bed facility provides all services including an emergency room, even thoug[h] most of its business is in heart care.

MedCath's hospitals are licensed as genera[l] acute-care facilities with a focus on patient[s] who have cardiovascular disease. The compa[-]ny's model is to "bridge the gap between th[e] practice of medicine and the business of med[-]icine" by partnering with cardiology physi[-]cians, according to the company's Web site. Ed French, president and CEO of MedCath, said the company's hospitals are unique because o[f] their physician joint ownership and stron[g] core of heart services.

As the various players push their own agendas, there is still ambiguity about how to distinguish a specialty hospital from a general acute-care hospital. The AHA's Coyle said she is hopeful the new Congress will be more favorable to addressing the issues of physician ownership and self-referral. Rep. Pete Stark of California, the ranking Democrat on the House Ways and Means Health Subcommittee and longtime opponent of physician ownership, offered a written statement on the topic: "For years, I've been concerned that physician-owned hospitals are pulling profit centers out of community hospitals. In the next Congress, I hope to work with colleagues on both sides of the aisle to stop their proliferation." «

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companies also develop outpatient surgery and imaging centers.

They represent a much different challenge than the specialty hospitals with physician investors that were stymied by a moratorium on their construction that began in 2003 and ended this year, Goldstein said. Unlike those hospitals, these are general acute-care hospitals, with emergency and general surgery departments and treatment of "bruises, bumps and lumps," she said.

Like specialty hospitals, these new hospitals often include physician investors, Goldstein added, but with a twist: They're primary-care physicians instead of specialists and surgeons. Primary-care physicians control referrals to specialists and surgeons and can influence—although not induce explicitly—where the specialists and surgeons practice on patients referred to them, she said.

Whether this competitive threat has staying power "will be a function of whether these providers can get managed-care contracts," Goldstein said. "They're not in it for the Medicare/Medicaid population, and they can only live so long on out-of-network patients." «

What do you think?

Write us with your comments. Via e-mail, it's mhletters@crain.com; by fax, 312-280-3183.

American Hospital Association

TRENDWATCH

Impact of Limited-service Providers on Communities and Full-service Hospitals *September 2004, Vol. 6, No. 2*

Limited-service providers, often referred to as "niche" providers, are a growing presence in the health care field. These providers focus on specific conditions or procedures (e.g., heart, orthopedic, and surgical services) and include single-specialty and multi-specialty hospitals, ambulatory surgical centers (ASCs), and diagnostic testing facilities. They are more common in states without Certificate of Need (CON) regulations, and most are either partially or fully-owned by physicians.

The AHA estimates that there are well over 100 limited-service hospitals currently operating—nearly triple the number from 1997—and that approximately 30 more currently are under development.[1] In addition, 3,735 Medicare-certified ASCs currently are open, growing at a rate of 6 percent per year.[2]

The impact that these facilities have on patients and the broader health care delivery system is beginning to be better understood. Physicians' ability to refer to facilities in which they are owners has the potential to place the medical interests of the patient at odds with the financial interests of the physician. Past research in other practice settings indicates that the financial incentives created by physician ownership can lead to higher referral rates for services and potentially unnecessary utilization.[3]

The impact on broader access to care for the community is another concern. As owners of the facilities to which they refer, physicians have both the ability and the financial incentives to shift the well-reimbursed services and patients to their own facility. This practice can drain essential resources from full-service hospitals that rely on these patients to cross-subsidize money-losing, but essential community services (e.g., burn, emergency and trauma care) and care for low-income populations.

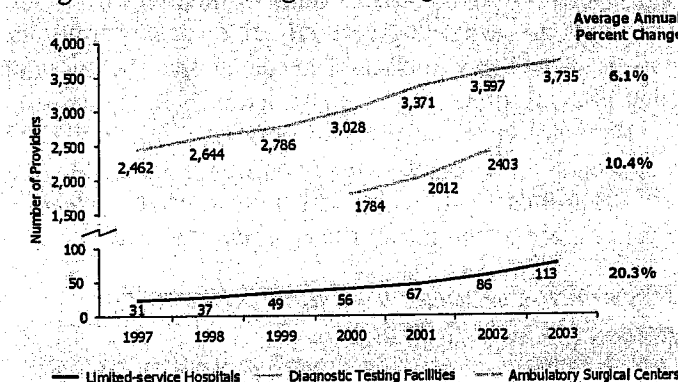
Last year, Congress recognized these concerns and placed an 18-month moratorium on physician self-referral of Medicare and Medicaid patients to new limited-service hospitals while the Centers for Medicare & Medicaid Services (CMS) and the Medicare Payment Advisory Commission (MedPAC) study the issue.

New medical technology and the associated shift of care to outpatient settings have contributed to the growth of limited-service providers. Widespread physician access to capital, the prospect of more operational control and productivity, and high profit margins have made limited-service providers attractive ventures for physicians.

This issue of TrendWatch highlights the trends and implications of the growth of limited-service providers.

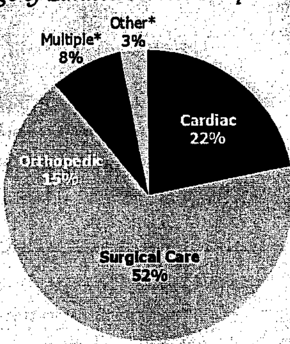
The number of limited-service providers is growing rapidly.

Chart 1: Number of Limited-service Hospitals, Ambulatory Surgical Centers, and Diagnostic Testing Facilities, 1997-2003



Newer limited-service hospitals are focusing on cardiac, orthopedic, and surgical care...

Chart 2: Percentage of Limited-service Hospitals by Specialty, 2004

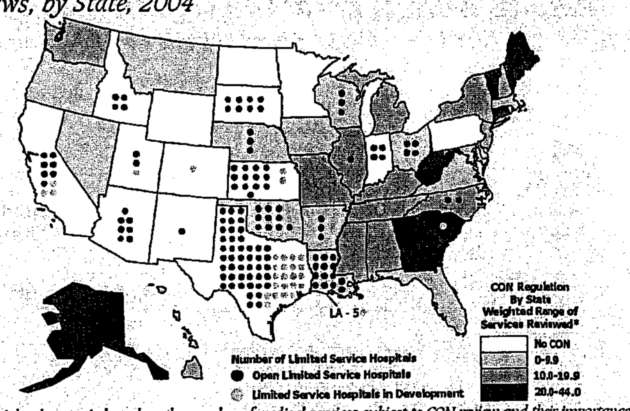


n = 170 Limited-service Hospitals open and in development

Note: Consistent with the Medicare Modernization Act, long-term acute care, cancer, psychiatric, children's, and rehabilitation hospitals are not included in the definition of limited-service hospitals.
**Multiple includes a combination of orthopedic, surgical and/or cardiac. Other includes limited-service hospitals that could not be identified with respect to specialty area.*

...with the greatest proliferation in states having no CON regulations.

Chart 3: Number of Limited-service Hospitals Relative to CON Laws, by State, 2004



**Weighted range is based on the number of medical services subject to CON review and their importance; facilities in development reported by state hospital associations, data may be incomplete*

The Lewin Group

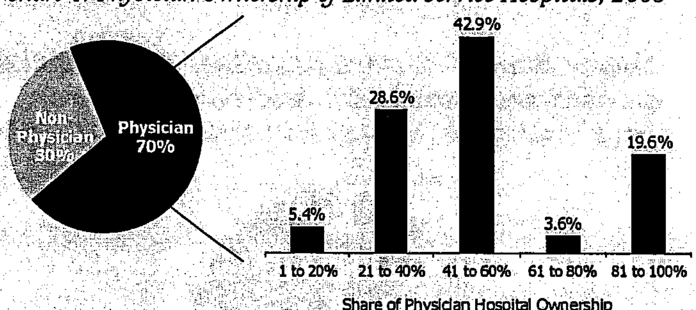
Physician ownership of limited-service providers raises concerns about self-referral...

Seventy percent of limited-service hospitals currently operating or under development have some level of physician ownership. The share of physician ownership averages just over 50 percent.[1] Physicians also have ownership stakes in approximately 83 percent of ASCs.[2]

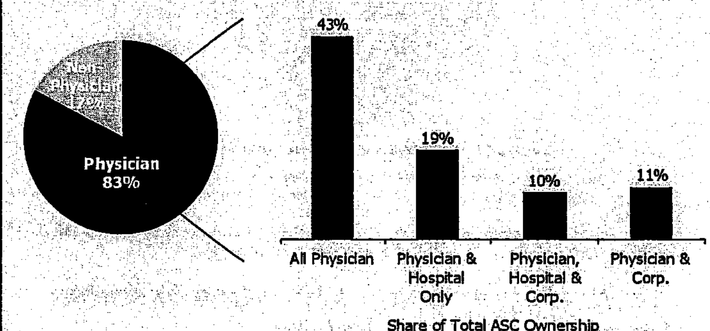
The ability of physicians to refer to facilities in which they have an ownership interest can create an inherent conflict between the clinical needs of the patient and the financial interests of the physician. The opportunity for financial gains beyond professional fees, including a share in facility profits and an equity interest, can create incentives to increase and direct patient referrals based on economic rather than clinical criteria.[3]

Physician ownership of limited-service providers is substantial...

Chart 4: Physician Ownership of Limited-service Hospitals, 2003



Physician Ownership of ASCs, 2004



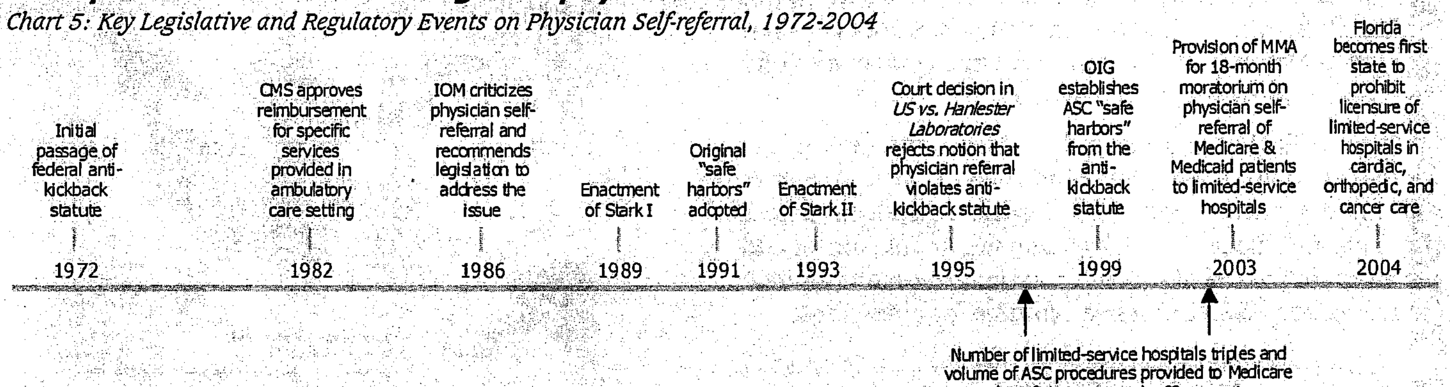
In 1972, Congress passed the federal anti-kickback statute to address the issue of improper financial inducements. The statute prohibits entities from offering or receiving remuneration tied to the referral of Medicare and Medicaid patients. In 1991 and 1999, the Office of Inspector General (OIG) promulgated exceptions to the federal anti-kickback statute, which, in addition to statutory exceptions, are collectively known as "safe harbors." These rules protect certain types of activities (e.g., investment in certain types of Medicare-certified ASCs, joint ventures, and group practices) from violation under the federal anti-kickback statute, subject to certain requirements. Various interpretations of these laws have facilitated physician investment in limited-service providers.[4]

In 1989, Congress enacted the Ethics in Patient Referrals Act to limit physician self-referral. Under the original statute (commonly referred to as Stark I), a physician cannot refer Medicare patients to a clinical laboratory in which the physician, or an immediate family member, has a financial interest, subject to certain exceptions. In 1993, the law was extended (Stark II) to cover referrals for additional "designated health services,"[5] including radiology and inpatient and outpatient hospital services, among others.[6]

The Stark law contains a number of exceptions. In particular, the "whole hospital" exception permits self-referrals by physicians when they have ownership in the whole hospital, as opposed to a subdivision of a hospital. The legislative intent of the exception was to allow for ownership in general hospitals that offer a full spectrum of health care services, where a single referral would produce little personal economic gain. Since limited-service hospitals are much smaller—often closer in size and the scope of services to a hospital department—the potential for personal financial gain to influence physician referral has raised concerns.[7] This exception allows physician self-referral to any inpatient or outpatient service offered by the "whole hospital" including diagnostic services, such as lab and imaging.

...despite various efforts to regulate physician self-referral.

Chart 5: Key Legislative and Regulatory Events on Physician Self-referral, 1972-2004



...and utilization of health care services.

Case studies document a discernible shift in volume when referring physicians acquire a personal financial interest in a limited-service provider. For example, a study in Louisiana found that physician investors in an ASC reduced referrals to the full-service hospital by approximately 50 percent, while non-investor surgical volume remained relatively constant.[1] Similarly, a study in South Dakota found that the number of cases at the full-service hospital fell by 77 percent upon the opening of an ASC.[2]

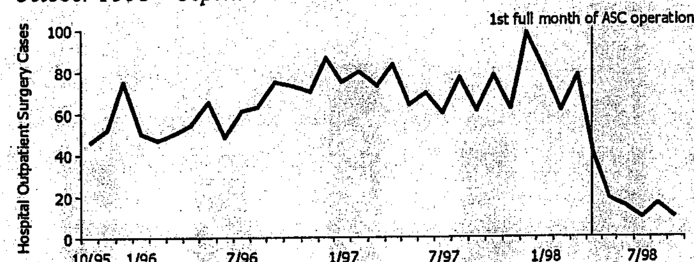
Physician self-referral also is linked to higher use of services. In 1989, the OIG found that patients of physician-owned clinical laboratories received 45 percent more laboratory services than Medicare patients in general.[3] Additionally, a 1994 GAO analysis of referral patterns of investor and non-investor physicians in Florida found physician owners ordered 54 percent more MRI scans, 27 percent more CT scans, 37 percent more nuclear medicine scans, 27 percent more echocardiograms, 22 percent more ultrasound services, and 22 percent more complex X-rays.[4]

Hospital and health plan leaders have expressed concern about the overall impact of physician-owned limited-service providers on access to care, utilization and costs. Financial incentives that promote greater service use may put patients at risk and drive up health care costs. Costs to the community may also increase due to the creation of duplicative capacity. The actions full-service hospitals must take in response to shifts in capacity and utilization may affect costs and access as well. These steps may include recruiting additional physicians to maintain emergency access to affected services, budget cuts and service reductions in other areas, or, when possible, negotiating higher rates with private payers for other services. In some cases, full-service hospitals may not be able to maintain services in affected areas, reducing access to care for the broader community.

Questions have been raised about the quality of care provided in certain limited-service settings. For example, in a recent report to Congress, MedPAC examined the growth of ASCs and the high rate of utilization of services at these facilities. Noting that regulation of ASCs is less stringent than that of hospital outpatient departments, the report called for "a better understanding of the quality of care provided in alternative settings, including safety, regulatory oversight, and clinical considerations."[5]

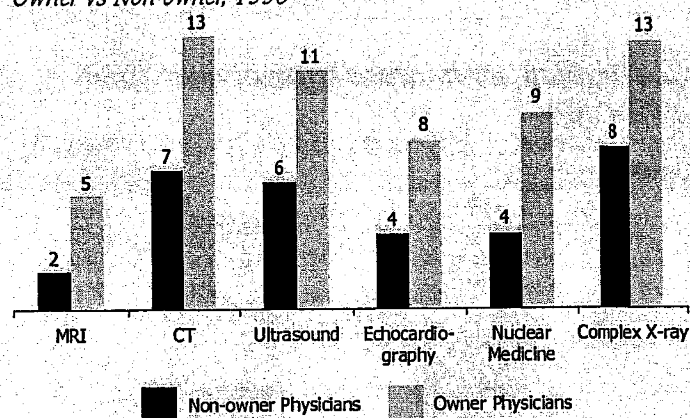
Physician ownership influences where physicians direct referrals...

Chart 6: Orthopedic Surgeries Performed by Physician Investors at a Full-service Hospital System Before and After ASC Opening, October 1995 – September 1998



...and the amount of care they provide.

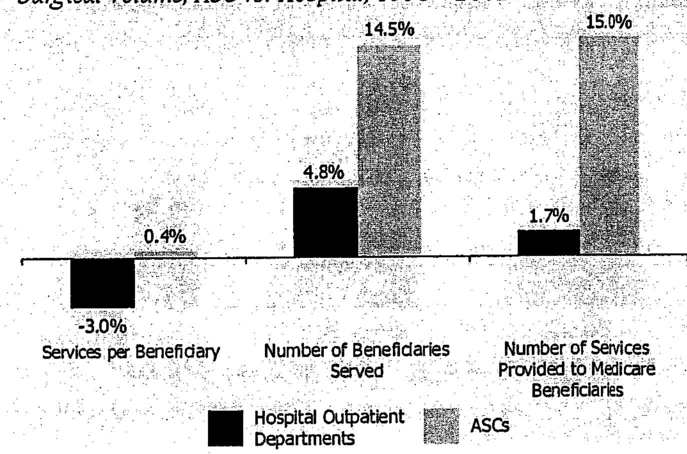
Chart 7: Number of Imaging Services Ordered per Physician, Owner vs Non-owner, 1990



NOTE: Information from Florida Health Care Cost Containment Board and Florida BCBS; analysis includes 16,157 physicians.

Medicare data reflects the impact of ASC growth on service use and setting of care.

Chart 8: Average Annual Percent Change in Medicare Outpatient Surgical Volume, ASC vs. Hospital, 1998 – 2002

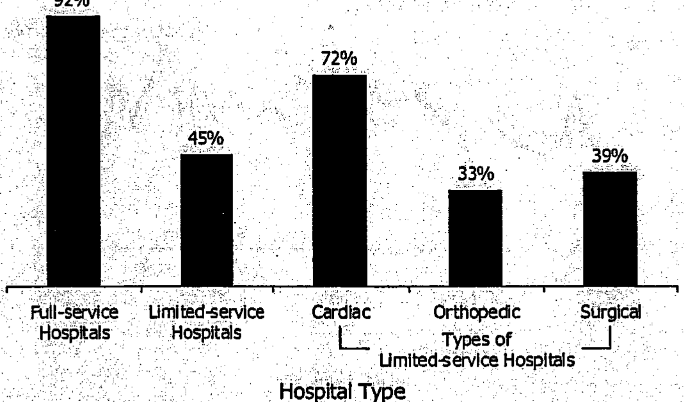


TRENDWATCH

Limited-service hospitals appear to focus on the most profitable services and patients...

Limited-service hospitals typically do not have emergency departments...

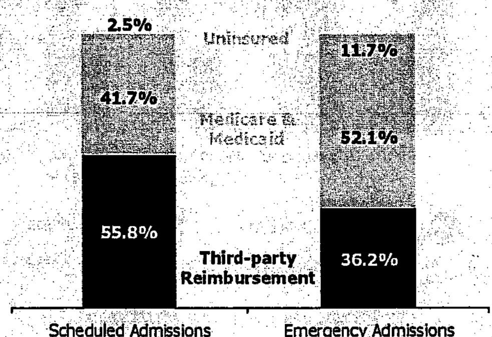
Chart 9: Percentage of Full-service and Limited-service Hospitals with Emergency Departments



Note: Data for general hospitals are from AHA's Annual Survey (2001). Specialty hospital data are from GAO's specialty hospital survey (2003), GAO's contacts with hospital administrators, and the CMS POS file (2003).

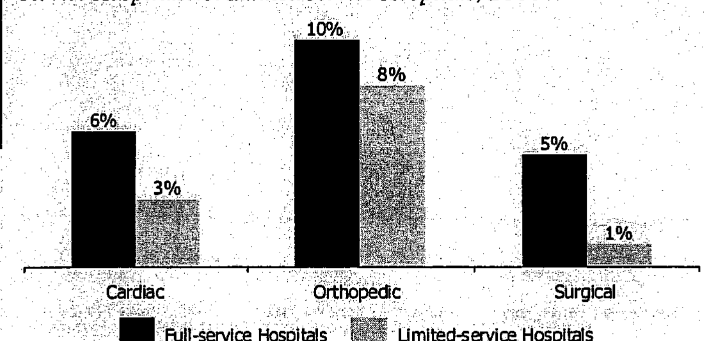
...affording them more control over their payer mix.

Chart 10: Percentage of Cases by Payer: Hospitals in Houston, TX, 2002



These facilities deliver a lesser proportion of their care to low-income patients...

Chart 11: Medicaid Patients as a Percent of Total Patients, Full-service Hospitals vs. Limited-service Hospitals, 2000



Note: Analysis based on HCUP data from six states. Compared limited-service hospitals to full-service hospitals in the same market area.

Physician owners have both the ability and financial incentives to direct patients to or away from the facilities in which they have an ownership interest. As such, limited-service hospitals tend to: 1) specialize in well-reimbursed services; 2) serve fewer high-acuity patients; and 3) serve fewer low-income and uninsured patients. Such practices can produce high returns for physician investors but place full-service hospitals at a disadvantage as they depend on a balance of services and patients to support the broader health needs of the community.

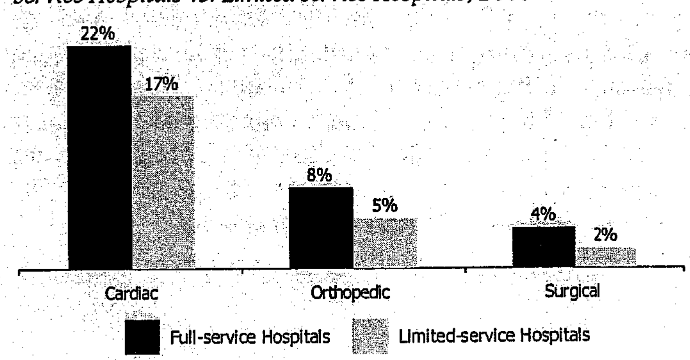
Payment relative to cost varies considerably depending on the type of service, the payer and the acuity level of patients. Heart, orthopedic and general surgical cases are among the most highly reimbursed relative to cost, and limited-service providers typically focus on these high volume, high margin services.[1]

Medicare and Medicaid pay less than private insurers for the same services, and providers receive little or no reimbursement for services to indigent patients. Medicare and many other payers reimburse a flat average rate for a specific case-type, regardless of patient acuity, with exceptions made for extremely high cost patients through outlier payments.[2]

Most limited-service hospitals do not have emergency departments (EDs),[3] affording them more control over their payer mix and patient acuity level. Unlike full-service hospitals, limited-service hospitals without EDs do not maintain costly standby capacity and do not have the obligation under the Emergency Medical Treatment and Labor Act (EMTALA) to screen and stabilize all patients, regardless of their ability to pay. Because emergency admissions are generally more acute and less stable than those that are elective, limited-service hospitals typically serve fewer high acuity patients relative to full-service hospitals.

...and serve a lower acuity patient population relative to full-service hospitals.

Chart 12: Severely Ill Patients as a Percent of Total Patients, Full-service Hospitals vs. Limited-service Hospitals, 2000



Note: Analysis based on HCUP data from six states. Compared limited-service hospitals to full-service hospitals in the same market area.

...limiting the ability of full-service hospitals to support the range of services essential to the community.

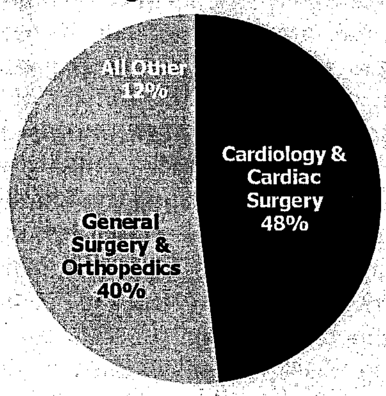
The rapid growth of limited-service providers raises concerns about their impact on care delivery in the community. As physicians move their practices to limited-service providers, they leave full-service hospitals less able to maintain the broad range of services vital to meeting community health needs.

The current payment system does not explicitly fund standby capacity for emergency, trauma and burn service categories, nor does it fully reimburse hospitals for care provided to Medicaid and uninsured patients. Full-service hospitals rely on cross-subsidies from some well-reimbursed services to be able to provide other under-reimbursed but essential community services.

These effects are illustrated in one midwest community after a physician-owned limited-service hospital opened in 1997. Three of four neurosurgeons—physician investors in the new facility—subsequently resigned from the full-service community hospital, significantly reducing neurosurgeon coverage in the community's only emergency department. To compensate for the gaps in emergency and trauma care, the hospital shifted to temporary staff coverage; however, this solution has proven difficult to maintain. In addition to the impact on the community at large, the hospital saw surgical volume drop across neurosurgery and other affected specialties (e.g. orthopedics). Operating room efficiency declined when elective cases were lost, but capacity for emergency cases had to be maintained.[1]

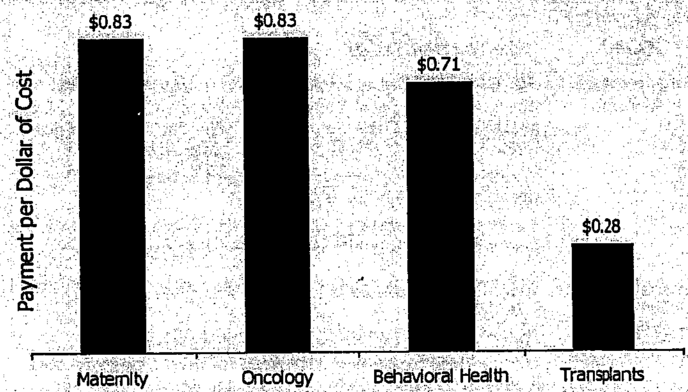
When physician-owners focus on well-paying services...

Chart 13: Percent of Net Income by Service in a Community Hospital System in the Southwest Region, 2003



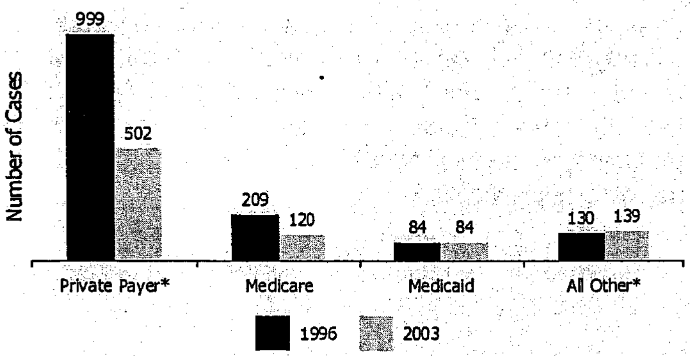
...full-service hospitals are less able to support essential, but money-losing care...

Chart 14: Payment per Dollar of Cost for Essential Services, a Community Hospital System in Southwest Region, 2003



...as they lose higher paying patients to limited-service hospitals.

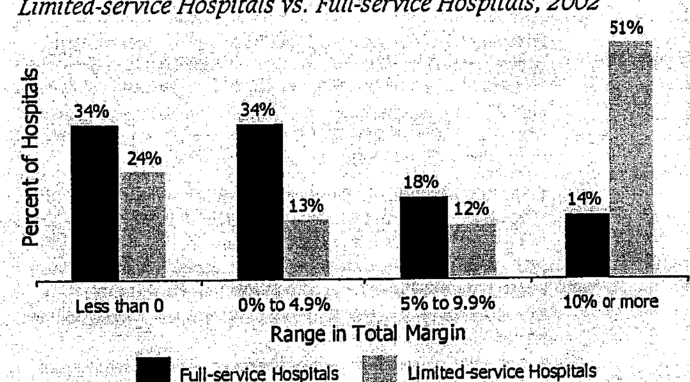
Chart 15: Changes in Orthopedic Cases, a Midwest Community Hospital After Surgical Hospital Opened in 1997, 1996-2003



"Private payer" includes BCBS, workers compensation, commercial insurance, managed contract care, and other insurance. "All other" includes CHAMPUS, self-pay and public health insurance.

These practices contribute to limited-service hospitals' higher profitability.

Chart 16: Percent of Hospitals by Range in Total Margin, Limited-service Hospitals vs. Full-service Hospitals, 2002

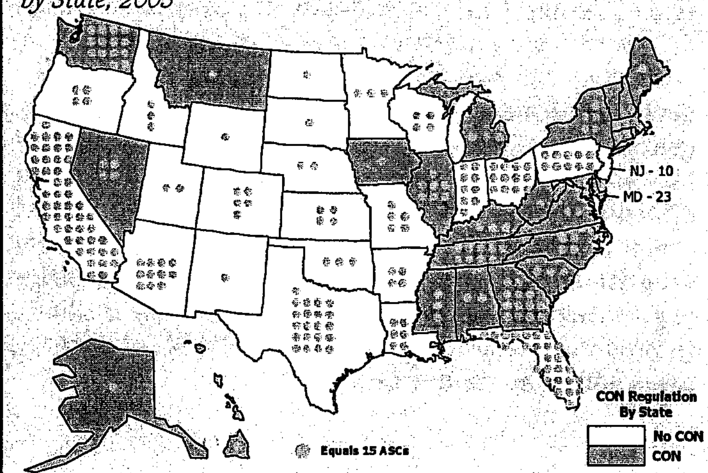


TRENDWATCH

Federal and state governments are attempting to address concerns with limited-service provider growth and referral.

ASCs are primarily located in states with minimal or no CON regulation.

Chart 17: Number of ASCs Relative to CON Laws Governing ASCs, by State, 2003



States are grappling with the challenge of further regulating limited-service providers.

Chart 18: Examples of State Legislative Activity, 2003

Types of Rules	*State Examples*
Emergency Services	**AZ, CA & LA:** *Proposed legislation* to establish standards for emergency services at limited-service hospitals and ASCs (e.g., immediate availability of emergency physician, transfer agreements) or prohibited licensure unless hospitals maintain an ED. **WA & NE:** *Vetoed legislation* to require limited-service hospitals to provide 24/7 ED services. **IL:** *Enacted Hospital Licensing Act* to require all hospitals to have emergency department in order to receive licensure.
Certificate of Need Regulations	**AL:** *Enacted legislation* to increase thresholds for certain CON exemptions. **IL:** Legislation extended CON sunset to July 1, 2008. **MA:** *Enacted legislation* to require all facilities to apply for state review to add new services or make capital improvements.
Types of Procedures	**CA:** *Vetoed legislation* to prohibit licensure for hospitals with limited inpatient services (e.g., surgical procedures). **FL:** *Enacted legislation* to prohibit licensure of limited-service hospitals and facilities with 65 percent of discharges in cardiac, orthopedic, and cancer care. **NJ:** *Enacted legislation* to levy 3.5 percent tax on certain physician-owned ASCs. **GA:** *Proposed legislation* to impose 6 percent provider fee on ASC, laboratory, or diagnostic or imaging services.
Safety Net	**NM:** *Proposed legislation* to provide emergency services to non-paying patients and low-income reimbursed patients in the same proportion as patients treated in acute-care general hospitals. **OK:** *Enacted legislation* to impose fee on limited-service hospitals who have not earned at least 30 percent of annual revenue from Medicare, Medicaid and uncompensated care.
Physician Ownership (Stark-like)	**CA, CO, IN, LA, MA, OH & KY:** *Proposed legislation* to prohibit physicians with ownership interest in limited-service provider facilities from making patient referrals to those facilities. **MI:** *Enacted law* that included federal anti-referral law (Stark) under unprofessional conduct for health professions. **SC:** *Implemented regulation* to extend the federal prohibition on self-referral to all patients. **WA & MO:** *Proposed* or *enacted* temporary ban on physician self-referral to new limited-service hospitals.

Various types of laws have been enacted to address issues of physician self-referral, capacity control and adequacy of health care delivery. Some of these endeavors, however, have been unsuccessful. Loopholes in some statutes, such as the "whole hospital" exception, have undermined many of the original goals.

Several forms of regulatory oversight focus on the supply of health care. For example, Certificate of Need (CON) regulations require that a permit be issued by a state agency before a health care facility may construct or expand, offer a new service or purchase equipment exceeding a certain cost. The purpose of CON laws was to prevent duplication of resources and limit excess bed capacity and services in communities. Congress required all states to enact CON laws in 1974, but later repealed that requirement and passed the responsibility onto states. Currently, 36 states and the District of Columbia have CON requirements, and most limited-service providers are located in states with no CON requirements, such as California and Texas.[1]

Federal and state governments have been proactive in addressing concerns around the growth and oversight of limited-service providers. When Congress passed the Medicare Modernization Act (MMA) in 2003, they placed an 18-month moratorium on physician self-referral under Medicare for new limited-service hospitals while MedPAC and the Department of Health and Human Services (HHS) study the issue. The law specifically covers cardiac, orthopedic and surgical hospitals but can be expanded at the discretion of HHS. Hospitals already in operation or under development as of November 18, 2003 are exempt. A bipartisan group of House members currently is pushing for further legislative action on limited-service providers, while a few states, including Washington and Missouri, have enacted or plan to enact a regulation banning physician self-referral to new limited-service hospitals, similar to the federal moratorium.[2]

At the state level, South Carolina has enacted more stringent Stark-like legislation by extending the federal prohibition on self-referral to all patients. Additionally, Illinois recently enacted legislation to require that all hospitals include a full-service ED, thereby making them subject to EMTALA, and Arizona proposed legislation to establish transfer agreements between full-service hospitals and limited-service providers.[3]

Limited-service providers raise broader issues about the health care system.

Limited-service providers have potentially significant effects on the health care system and on communities served. Subjects of greatest concern include the appropriateness of physician self-referrals, the role of competition in health care, and regulatory approaches that create unintended competitive advantages or disadvantages.

Proponents of physician-owned limited-service providers argue that competition from such facilities will lead to improved quality, service and efficiency. Others cite data suggesting that physician-owners and other investors can profit from such tactics as:

- Not taking on the commonly accepted roles and associated costs of a full-service hospital;
- Selecting a narrow range of service offerings; and,
- Using the physician-owners' ability to direct referrals to steer patients either to the facility in which they have a financial interest (self-referral) or to a full-service competitor.

Full-service hospitals are concerned that they will become unable to perform safety-net roles essential to their communities as limited-service facilities compete for patients. These safety-net roles include:

- Serving as a key access point for care for the nearly 45 million Americans without health care coverage, an expectation guaranteed by federal EMTALA requirements for hospitals having emergency departments.
- Providing standby capacity for routine emergencies, disaster readiness, trauma, burn units, and/or other essential community services.
- Delivering a wide array of services to a broad range of payers and patients of varying acuity levels.

This issue adds to the broader public policy debate about how best to provide affordable and accessible health care for all Americans.

Quotes from the Field

"Central to keeping the balance of services and community access is the issue of cross-subsidization. Full-service hospitals must rely on the ability to use revenues from the more highly reimbursed services to subsidize and sustain low- or no- profit services that are critically needed."
William Petasnick, President and Chief Executive Officer of Froedtert Hospital and Community Health System, Milwaukee, WI

"There are a lot of issues raised about the impact niche hospitals have on big hospitals — which are our health care safety net. There are also some questions about what type of disclosure a doctor needs to give a patient if that doctor owns part of the hospital." — Amanda Engler, spokeswoman for the Texas Hospital Association

"How can a doctor who is part owner of a for-profit [specialty provider] be expected to fulfill his or her duties towards his or her co-workers and in the same instance fulfill the duties towards the principal who is a not for profit hospital? This does not imply ill-will on the part of the doctor, it simply faces fundamental medical issues such as at which institution does the doctor place his or her patients....? We have often stated that an agent cannot serve two masters. This rule applies to medical professionals as well." — South Dakota Supreme Court ruling on an antitrust case involving Avera Health System and the Orthopedic Surgery Specialists

Endnotes:

Page 1: [1] The Lewin Group analysis of AHA state survey data, 2004

[2] CMS Office of the Actuary, 2004

[3] Hillman, BJ, Joseph, CA, Mabry, MR, Sunshine, JH, Noether, M., "Frequency and costs of diagnostic imaging in office practice—a comparison of self-referring and radiologist-referring physicians," *New England Journal of Medicine*, vol. 323, 1990; Mitchell, JM, Scott, E., "Physician ownership of physical therapy services: effects on charges, utilization, profits, and service characteristics," *JAMA*, vol. 268, 1992

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[2] American Association of Ambulatory Surgery Centers (AAASC) ASC Ownership Survey, February 2004

[3] Unland, James J, "Can Community Hospitals Survive Without Large Scale Health Reform?," *Journal of Health Care Finance*, Spring 2004

[4] Saner, RJ, Spindel, MP, and Fitzgerald, M, *New and Clarified Anti-Kickback Safe Harbors Issued*, Powers Pyles Sutter & Verville P.C., http://www.ppsv.com/issues/kickback.htm

[5] Designated health care services include: clinical laboratory; radiology; durable medical equipment; physical therapy; occupational therapy; radiation therapy services & supplies; parenteral & enteral nutrients, equipment & supplies; outpatient prescription drugs; prosthetics; home health services; and inpatient & outpatient hospital services

[6] Satiani, B, "Specialty Hospitals and the Stark Act," *Bulletin of the American College of Surgeons*, vol. 88, no. 11, 2003

[7] United States Government Accountability Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167, October 2003

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[3] Report to Congress, Office of Inspector General, *DHHS: Financial Arrangements Between Physicians and Health Care Businesses*, pages 18 and 21, May 1989

[4] United States Government Accountability Office, *Medicare Referrals to Physician Owned Imaging Facilities Warrant HCFA's Scrutiny*, GAO/HEHS-95-2, Oct. 1994

[5] MedPAC, *Assessing adequacy and updating payments for ambulatory surgical center services*, March 2003

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[2] "The Medicare Program Focuses on Outlier Payments to Hospitals," *BNA's Health Care Fraud Report*, vol. 6, no. 24, December 11, 2002; BNA's Medicare Report, vol. 13, no. 47, December 13, 2002

[3] United States Government Accountability Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167 Specialty Hospitals, October 2003

Page 5: [1] McManis Consulting, *Impacts of Niche Providers on Health Care Delivery*, Presentation to South Dakota Association of Healthcare Organizations Board, July 29, 2004; Note: In August 2004, the facility successfully recruited and employed a neurosurgeon.

Page 6: [1] American Health Planning Association, *National Directory of Health Planning, Policy and Regulatory Agencies*, Fifteenth Edition: February 2004

[2,3] State Niche Provider Legislation Overview, American Hospital Association, 2003

Sources:

Chart 1: The Lewin Group analysis of American Hospital Association state survey data, 2004; MedPAC analysis of Provider of Services file, 5% Standard Analytic File of ASC claims from CMS and MedPAC analysis of 5% Standard Analytic File of independent diagnostic testing facility claims from CMS as reported in MedPAC, *Ambulatory Care*, July 2004 (Data not available for all hospitals)

Chart 2: The Lewin Group analysis of American Hospital Association state survey data, 2004

Chart 3: The Lewin Group analysis of American Hospital Association state survey data, 2004; state hospital associations; American Health Planning Association, *National Directory of Health Planning, Policy and Regulatory Agencies*, Fifteenth Edition: February 2004

Chart 4: United States Government Accountability Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, GAO-03-683R Specialty Hospitals, April 2003; American Association of Ambulatory Surgery Centers ASC Ownership Survey, February 2004

Chart 5: Sec 1877 42USC & 1395nm; Public Law 108-173; 42USC & 1320-a7(b); Saner, RJ, Spindel, MP, and Fitzgerald, M, *New and Clarified Anti-Kickback Safe Harbors Issued*, Powers Pyles Sutter & Verville P.C., http://www.ppsv.com/issues/kickback.htm; Physician Self-Referral Education Resource Web Guide, *Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships*, http://www.cms.hhs.gov/medlearn/refphys.asp; Vaughan-Sarrazin, MS, Hannan, EL, Gormley, CJ, Rosenthal, GE, "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Surgery in States with and without Certificate of Need Regulation," *JAMA*, vol. 288 no. 15, 2002

Chart 6: Lynk, William J and Longley, Carina S, "The Effect of Physician-Owned Surgicenters on Hospital Outpatient Surgery," *Health Affairs*, vol. 21 no. 4, July/August, 2002

Chart 7: United States Government Accountability Office, *Medicare Referrals to Physician Owned Imaging Facilities Warrant HCFA's Scrutiny*, GAO/HEHS-95-2, Oct. 1994

Chart 8: MedPAC analysis of the 5% Standard Analytic files of ASC and hospital outpatient department claims from CMS as reported in MedPAC, *Ambulatory Surgical Center Services*, March 2004

Chart 9: United States Government Accountability Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167, October 2003

Chart 10: HCA analysis of Houston market data, 2004

Chart 11: United States Government Accountability Office, *Specialty Hospitals: Geographic Location, Services Provided, and Financial Performance*, GAO-04-167 Specialty Hospitals, October 2003

Chart 12: United States Government Accountability Office, *Specialty Hospitals: Information on National Market Share, Physician Ownership, and Patients Served*, GAO-03-683R Specialty Hospitals, April 2003

Charts 13 & 14: Data provided by a hospital system in the southwest United States. Relative gains and losses will vary by community based on demographics and payer environment. Net income represents earnings before interest, taxes, depreciation, and amortization at the service level.

Chart 15: The Lewin Group analysis of data from Rapid City Regional Hospital, Rapid City, SD

Chart 16: The Lewin Group analysis of HCRIS data, 2002. Includes 69 limited service providers who had been in operation for at least 2 years (at least one subsequent cost report filed). Community hospitals includes all other PPS hospitals.

Chart 17: The Lewin Group analysis of CMS Provider of Service File, 1Q04 release; American Health Planning Association, *National Directory of Health Planning, Policy and Regulatory Agencies*, Fifteenth Edition: February 2004

Chart 18: 2003 State Niche Provider Legislation Overview; SC Provider Self-Referral Act, 44-113; American Hospital Association; WA State Hospital Association; Medical Association of GA

TrendWatch is a series of reports produced by the American Hospital Association and The Lewin Group highlighting important and emerging trends in the hospital and health care field.

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